

## **Addendum #2–Description of Core Assessment Domains for Assessing Complex Trauma in Infancy and Early Childhood**

### *Core Assessment Domains*

Core domains for assessing complex trauma in infancy and early childhood are listed below:

1. Child history of trauma exposure and assessment of any ongoing risks to safety
2. Child developmental functioning
3. Child trauma-related symptoms
4. Child behavioral symptoms
5. Quality of the child-caregiver relationship
6. Caregiver functioning
7. Socio-cultural context (e.g. social and community supports)

Each of these domains is described below along with assessment tools that specifically target each domain:

### ***Core Assessment Domain #1: Child History of Trauma Exposure and Ongoing Risks to Safety.***

Assessment of child trauma history should ideally be conducted using both interviews with caregivers using a structured trauma screening instrument and comprehensive review of medical records and records from other child-serving agencies such as Child Protective Services.

Assessment should include a focus on both what the child has directly experienced and what he or she may have indirectly experienced. For example, the mother of a 12-month-old child was murdered by the child's father but the child did not witness the event. However, this event had a tremendous impact over the child's development. The impact was due to the sudden loss of her mother and the severe negative impact on the aunt's functioning. The family was involved in prolonged legal proceedings; and furthermore, the child's resemblance to her father triggered her aunt to often respond very intensely when the child had tantrums or displayed angry emotions. Throughout her development, the child witnessed continual family upheaval and learned of the many details of what had occurred.

In regards to screening for adverse and traumatic events, the American Academy of Pediatrics has developed materials for pediatricians on how to support adoptive and foster families. The Trauma Guide contains coding tips for evaluations involving screening and anticipatory guidance related to trauma and other mental health and developmental concerns. Please refer to the below website for more information on the guide: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx>

Assessment tools that can be used for in-depth trauma screening of infants, toddlers, and preschoolers are described below:

- 1) *Child Trust Events Survey (CTES)*. The CTES is a screening instrument used with caregivers of children under age 8. It contains 26 items about traumatic events, including accidents, abuse, violence, medical trauma, and loss of caregivers. Items were derived from the Traumatic Events Screening Inventory for Children (TESI-C1) and the UCLA PTSD Index. The CTES also includes all the items identified as Adverse Childhood Events (ACEs).
- 2) *Traumatic Events Screening Inventory Parent Report Revised (TESI-PRR; Ghosh Ippen et al., 2002)*. This 24-item semi-structured interview can be used in a variety of settings to assess children's exposure to a variety of stressors including accidents, medical trauma, exposure to

family and community violence, experiencing the death of someone close, and physical assaults. The measure is typically used with children under age 6, but there is no upper age limit, and is available for free in English and Spanish from the first author.

- 3) *Young Child PTSD Checklist (YCPC; Scheeringa, 2013)*. This measure, for children aged 1-6, includes a 12-item trauma screen. The measure can be downloaded from the below website: <http://www.infant institute.org/measures-manuals/>

### ***Core Assessment Domain #2: Child Developmental Functioning.***

Young children's developmental functioning, including emotional and physiological regulation, motor, cognitive and social functioning, with an emphasis on the attachment relationship with the caregiver, are often negatively impacted by trauma exposure. Infants often respond to stressful events by showing delays or regressions in development (e.g. language, motor, and social capacities) or disruptions in regulatory processes such as sleep, appetite, toileting, and emotion regulation. This domain is best assessed using observational methods including standardized assessments that incorporate direct assessment of the child, a few of which are described below:

- 1) *Bayley Scales of Infant Development (BSI-III; Black & Matula, 1999)*. This instrument can be used by a range of professionals (early interventionists, Speech Language Pathologists, Occupational Therapists, Physical Therapists, Pediatric Nurse Practitioners, and Psychologists) with children from 1-42 months of age. The Bayley assesses developmental functioning in 5 different areas: Cognitive, Communication, Physical, Social Emotional and Adaptive and includes a caregiver-report portion; therefore, it is not exclusively clinician-based.
- 2) *Mullen Scales of Early Learning (MSEL; Mullen, 1995)*. This assessment can be used by trained Bachelor's level staff with children aged from 0 to 5 years and 8 months. It yields normative scores on a Gross Motor scale as well as on four cognitive scales (Visual Reception, Fine Motor, Receptive Language, and Expressive Language) and on a single Early Learning composite score.
- 3) *Infant-Toddler Developmental Assessment (IDA; Provence, Erikson, Vater, & Palmeri, 1995)*. This assessment is used for children aged 0 to 3 years and was designed to identify those who are developmentally at risk. The IDA is completed by a multidisciplinary team in collaboration with caregivers over multiple assessment sessions that include an initial parent interview and developmental observation. The measure assesses the following 8 domains: Gross Motor, Fine Motor, Relationship to Inanimate Objects (Cognitive), Language/Communication, Self-help, Relationship to Persons, Emotions and Feeling States (Affects), and Coping.

### ***Core Assessment Domain #3: Child Trauma-Related Symptoms.***

There are comprehensive structured and semi-structured diagnostic tools available, including: 1) the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, 2) Preschool Age Psychiatric Assessment and 3) the Diagnostic Infant and Preschool Assessment, for use by trained mental health providers. Each of these tools has a module for assessing trauma-related symptoms and also enables the practitioner to assess for comorbid conditions. These tools help providers recognize mental health and developmental concerns in infants and young children and guide clinical formulation so that parents and other professionals can develop effective treatment plans. Examples of assessment tool in the public domain are provided below:

- 1) *Young Child Post-Traumatic Stress Disorder (PTSD) Screen (Scheeringa, 2010)*. This measure is a free 6-item questionnaire to be completed by parent or as an interview. It is used for children ages 0-5. The questionnaire is available at the following website: <http://www.infant institute.org/measures-manuals/>

- 2) *Young Child PTSD Checklist (YCPC; Scheeringa, 2013)*. This measure, for children ages 1-6, includes a 12-item trauma screen (described above) and 29 additional items targeting trauma-related symptoms, consistent with the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). The measure can be downloaded from the following website: <http://www.infantinstitute.org/measures-manuals/>
- 3) *Pediatric Emotional Distress Scale (Saylor, 2002)*. This 21-item caregiver-report questionnaire, for children ages 2 -10, was designed to rapidly assess and screen for elevated symptomatology in children following exposure to a stressful and/or traumatic event. It consists of 17 general behavior items and 4 trauma-specific items and assesses behaviors that have been identified in the literature as associated with experiencing traumatic events. The measure yields scores on the following scales: 1) Anxious/Withdrawn, 2) Fearful, and 3) Acting Out.

**Core Assessment Domain #4: Child Behavior Problems.**

Because complex trauma exposure may result in complex sequelae and comorbid conditions, a general assessment of the young child's behavioral functioning using standardized instruments is recommended. Below are some examples of tools that may be useful:

- 1) *The Survey of Wellbeing of Young Children (SWYC)*. This free comprehensive screening instrument for children under 5 years of age includes sections on behavior, emotions, development, and family risk factors. The entire instrument requires 15 minutes or less to complete and is straightforward to score and interpret.
- 2) *The Early Childhood Screening Assessment (Gleason et al., 2010)*. This 40-item caregiver report measure identifies children ages 18 - 60 months at high risk for mental health problems. The measure has been used extensively in pediatric primary care settings, early childhood mental health clinics, and childcare settings. Childcare versions are available. The measure can be downloaded from the following website: <http://www.infantinstitute.org/measures-manuals/>
- 3) *Infant-Toddler Social and Emotional Assessment (ITSEA; Carter & Briggs-Gowan, 2000)*. This 166-item parent-report questionnaire assesses social-emotional problems and competencies in infants and toddlers aged 12 - 36 months. Competencies refer to behaviors that reflect the achievement of mental-age appropriate milestones in social-emotional development. Social-emotional problems refer to behaviors that may interfere with infant/toddler functioning or reflect failure to achieve mental-age appropriate social-emotional competencies. The items are worded to be relevant and age-appropriate to younger children. A brief 42-item version of this measure, the Brief Infant-Toddler Social and Emotional Assessment (BITSEA), is also available.
- 4) *NICHQ Vanderbilt Assessment Scales (NICHQ)*. This measure includes a 22-item questionnaire for teachers and a 55-item questionnaire for parents to complete. It allows for assessment of comorbid mental health disorders. The following website provides more information: <http://www.chadd.org/> or <http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales>

**Core Assessment Domain #5: Quality of the Caregiver-Child Relationship.**

The child's relationship with the caregiver represents a critical domain of assessment given that development unfolds in the context of the child's primary attachment relationships. Prior research has shown that traumatic experiences can negatively impact both the child's and the caregiver's responses to each other and their ability to connect. For example, traumatic experiences in early childhood, including infancy, can undermine the young child's capacity to trust the adults' ability to keep him or her safe. This can markedly affect the child's capacity to use adults to regulate and

to trust them as a safe base from which to explore the environment, possibly leading to either reduced or reckless exploration or negative patterns of behavior. Trauma reminders and trauma-related expectations that are unbound by language, because they occurred during the preverbal period, may continue to disrupt the child's functioning. This is particularly true if caregivers are unaware of such reactions or are unable to respond in ways that enhance regulation and offer new experiences.

**Behavioral Observation of Child and Caregiver:** The caregiver-child relationship is typically best assessed through direct behavioral observation. There are different approaches for observing interactions between the caregiver and child. Common components include: free play, clean-up, problem-solving tasks, and a separation and reunion from the caregiver. The separation-and-reunion component allows the clinician to assess; 1) if and how well the caregiver prepares the child for the separation, 2) how the child responds to stress and separation, 3) how the caregiver responds to any cues of distress by the child and supports the child on reunion if needed, and 4) how the child receives the caregiver and is comforted upon return. Not all observations include the separation-and-reunion component, which is an important factor to consider when selecting an assessment approach. As behavioral observation in assessing infants and young children for complex trauma is a growing area, there are Infant Mental Health specialists nationwide that are specifically being trained in doing assessments such as the Parent-Child Structured Play Interaction ("the Crowell Procedure"). Accordingly, many child welfare organizations have made a commitment to training clinicians to conduct this type of assessment. Specific parent-child observation approaches are listed below:

- 1) *"Parent-Child Structured Play Interaction"* (often referred to by the author's last name-"the Crowell Procedure"; (Crowell & Feldman, 1988; 1991; Crowell, Feldman & Ginsburg, 1988). This procedure is typically used in clinical settings with children ages 12 - 60 months but has been used with children as young as 7 months provided they can sit up independently. It involves a series of eight episodes designed to elicit behaviors that allow the clinician to focus on the relationship between a child and his or her caregiver in a setting that is unstructured enough to allow for "real-life" or spontaneous interactions. This procedure requires 45 to 60 minutes to complete. The eight episodes include free-play, clean-up, a bubble blowing episode, four increasingly difficult problem-solving tasks, and a separation/reunion episode. These episodes allow the clinician to see 1) how comfortable and familiar the parent-child dyad is with each other, 2) how the dyad negotiates transitions, 3) the dyad's ability to play and problem-solve together, 4) their use of shared affect (positive and negative) to communicate, 5) the caregiver's ability to read the child's cues accurately and to respond supportively to them, 6) the child's ability to use the caregiver as a secure base, and 7) attachment behaviors.
- 2) *The Massie-Campbell Attachment During Stress Scale (ADS)*. This measure is often referred to as "The Massie-Campbell" and is a one-page guide to structured observation. It is used to observe mother-infant (0-18 months old) interactions and assess insecure attachment behaviors. It was originally designed to be used in pediatric clinics to screen for behavioral markers of insecurity but can be used in any other setting that is mildly stressful. It is a valuable clinical tool in that it can be utilized in the home environment during mildly stressful events such as diaper changes, bath time, or mealtime, when attachment related behaviors may be activated. It codes infant and mother behavior in 6 core areas: gazing, vocalizing, holding, touching affect, and proximity. It is inexpensive, quick and easy to "administer" and score, and is especially helpful because both parent and infant behaviors are observed and coded.
- 3) *The NCAST Parent-Child Interaction Scales (PCI)*. This measure assesses caregiver-child communication and interaction during either a feeding situation (birth to 12 months) or a

teaching situation (birth to 36 months). Both the Feeding Scale and the Teaching Scale assess parents on four subscales (Sensitivity to Cues, Response to Distress, Social-Emotional Growth Fostering and Cognitive Growth Fostering) and infants on two subscales (Clarity of Cues and Responsiveness to Caregiver). Both require training by a certified Nursing Child Assessment Satellite Training (NCAST) instructor. The instrument can be accessed from the following website: [https://www.ncast.org/index.cfm?fuseaction=category.display&category\\_id=24](https://www.ncast.org/index.cfm?fuseaction=category.display&category_id=24)

- 4) *The Parenting Stress Index, Fourth Edition (PSI-4) and the Parenting Stress Index, Fourth Edition Short Form (PSI-4-SF)*. These two measures are not based on observations, but are two widely used pen and paper measures that assess this domain. Both are designed to measure different aspects of the parent-child relationship in children aged 0-12. The PSI-4 contains 120 items and assesses for stress in three broad domains: child characteristics, parent characteristics, and situational/demographic life stress. The PSI-4-SF contains 36 items derived from the PSI-4 and is divided into three domains: Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC).
- 5) *The "Still Face Paradigm."* This assessment is designed for children as young as 6 months old. It is a valid assessment of functioning but used much more for research than in clinical practice. There are Infant Mental Health experts who find this assessment useful in assessing the quality of the caregiver-child relationship; however, others note that, outside of research settings, it is not readily used in community practice. The Paradigm has been described as an experimental procedure for studying infant social and emotional development. During the experiment, an infant and a parent interact playfully before the parent suddenly stops responding and looks away. After a short period, the parent reengages with the infant. The infant's reaction to a suddenly unresponsive parent and his or her behavior when the parent resumes interaction, have been used to study many aspects of early social and emotional development.

#### ***Core Assessment Domain #6: Caregiver Functioning.***

Caregiver depression and caregiver PTSD symptoms represent core aspects of caregiver functioning that are critical to assess. Both have been found to be prevalent in caregivers of infants who have experienced trauma and have the potential to negatively affect the child's development. Below are screening tools that assess these caregiver symptoms:

- 1) *Center for Epidemiologic Studies: Depression Scale (CES-D; Radloff, 1977)*. This self-report questionnaire was designed to screen for a major depressive episode. The scale was revised as the CESD-R and consists of 20 items and measures symptoms defined by the DSM-5 for a major depressive episode.
- 2) *MDE Screener (Muñoz, 1998)*. The MDE (Major Depression Episode) Screener was adapted from the major depression items in the Diagnostic Interview Schedule (DIS) and consists of 18 items. It is intended to screen for three groups according to self-report: 1) those with no history of MDEs, 2) those with a past history of MDEs, and 3) those with current MDEs.
- 3) *PTSD Symptom Scale Interview (PSS-I; Foa, Riggs, Dancu, & Rothbaum, 1993)*. The PSS-I is a 17-item semi-structured interview that assesses the presence and severity of DSM-IV PTSD symptoms. The measure was revised in 2013 to make it consistent with the DSM-5. The revised version (PSS-I-5) can be found from the following website: <https://www.div12.org/wp-content/uploads/2014/11/PSSI-5-Manual.pdf>

#### ***Core Assessment Domain #7: Socio-cultural context (e.g. social/community supports).***

It is important to have a comprehensive understanding of the environment in which a child experienced the trauma, as well as their current environment. A greater number of social and

community supports available to the family and caregivers may mitigate some of the impact of the trauma. While no specific measure is being recommended for this domain, information on social and community supports should be collected as part of a comprehensive assessment. Moreover, the culture/race/ethnicity of the child and family being assessed should be considered in the selection of assessment tools and interventions. Please refer to the website below for more information on the use of trauma-informed interventions with diverse cultural groups:

[http://www.nctsnet.org/nctsn\\_assets/pdfs/CCG\\_Book.pdf](http://www.nctsnet.org/nctsn_assets/pdfs/CCG_Book.pdf)